

TEXAS BOARD OF LICENSURE FOR PROFESSIONAL
MEDICAL PHYSICISTS
1100 West 49th Street
Austin, Texas 78756-3183
512/834-6655
Complaints Only 1-800-942-5540

This is an application for Licensed Medical Physicists. Please carefully read the attachments which consist of the following items:

1. Declaration Form
2. General Application Form
3. Professional Reference Form (Form A)
4. Verification of Licensure (Form B)
5. Specialty Affidavit (Form D)
6. Self-Employment Affidavit (Form E)
7. Professional Experience (Form F)
8. Agreement of Supervision (Form H)
9. The Medical Physics Practice Act (hereinafter referred to as “the act”)
10. Rules relating to the licensing of Medical Physicists (hereinafter referred to as “the rules”)

Effective JANUARY 1, 1992, a person practicing medical physics in Texas must either be licensed Medical Physicist or be exempt* from licensure.

The act allows a physicist to qualify for Texas licensure in several different ways. The following summary is condensed from the rules and the act and is not intended to be a complete list of all application requirements.

- A. Texas Licensure Without Examination (Not available after 8-31-94)
- B. Texas Licensure with Examination (Declaration Form, Methods B1 B2, B3) for a person who has:
 1. a master’s or doctoral degree AND
 2. has successfully completed two (2) years of full-time work experience in medical physics during the 5-year period preceding the date of application; AND
 3. have successfully completed an examination approved by the Board.
- C. Texas Licensure for Non-Texas Residents With An Out-of-State License (Declaration Form, Method C) for a non-Texas resident who possesses a current license to practice medical physics in another state, territory, or country – a state registration number assigned by a radiation control authority does not constitute a “license”.
- D. Texas Temporary License (Declaration Form, Method D) for a person who has a master’s or doctoral degree but who has NOT successfully completed both:
 1. two (2) year period of full-time work experience in medical physics during the 5-year period preceding the date of application; AND
 2. successful completion of an examination approved by the Board.

* The exemptions are set out in §601.5 of the rules and Section 602.202 of the act. If you have questions or concerns about whether your practice is exempt, please send a letter to the Board office detailing the reasons why exemptions apply to your practice. The Board will consider and reply to your questions or concerns.

November 2003

TEXAS BOARD OF LICENSURE FOR PROFESSIONAL MEDICAL PHYSICISTS
1100 West 49th Street
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DECLARATION FORM

READ CAREFULLY. USE THIS FORM TO INDICATE HOW YOU ARE QUALIFYING FOR A MEDICAL PHYSICIST LICNESE.

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.tdh.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

I. Name _____	Date of Application _____
II. Type of License Requested (Do not check more than one. If more than one applies, fill out a separate form). A. _____ License B. _____ Temporary License	
III. Specialty Requested (One or more may be checked). If more than one is checked complete Form D <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> A. ____ Diagnostic Radiological Physics B. ____ Therapeutic Radiological Physics </div> <div style="width: 48%;"> C. ____ Medical Nuclear Physics D. ____ Medical Health Physics </div> </div>	
IV. NONREFUNDABLE Application processing and initial licensing fee: NOTE:: Recent legislation (HB2985, 78 th Regular Session, 2003) requires the program to assess and collect fees to fund the Office of Patient Protection (OPP) within the Texas Health Professional Council. Effective January 1, 2004, there is an additional \$5.00 fee for each new application for licensure. \$130.00 for first specialty on initial application (the \$130 fee includes the additional OPP fee) and \$50.00 for each additional specialty requested on this application. Additional specialties on subsequent application are \$75.00 each. (Refer to Section 601.4 of the rules)	
V. Indicate ONE Method of Qualifying for License/Specialty Requested. Place and "X" in the space beside the ONE method you choose. Provide all items listed after the method you choose.	
A. LICENSURE WITHOUT EXAMINATION. Not available after 8-31-94.	
B. LICENSURE WITH EXAMINATION ____ B1. [References: Act - Sec. 602.206 and 602.207; Rules, Sec. 601.8(a)(1)(A)] <ul style="list-style-type: none"> Official transcript (including an official school seal) denoting a master's or doctoral degree in physics, medical physics, biophysics, radiological physics, medical health physics, or equivalent courses; Two (2) years of full-time experience in the medical physics specialty applied for during the five (5) year period preceding application for an annual license; AND An additional six (6) months of work experience during the five (5) year period preceding this application for each additional medical physics specialty requested; AND Proof of having passed examination(s) approved by the Board as set out in §601.8 of the rules, (copy of certificate); AND Three (3) professional references: two (2) medical physicists and on (1) physician practicing in the specialty area for which application is made. 	

___ B2. [References: Act, Sec. 602.206 and 602.207; Rules, Sec. 601.8(a)(1)(C)]

- Official transcript (including an official school seal) denoting a non-physics Master's or doctoral degree and at least 20 semester hour credits as described in Section 601.8(a)(1)(C) of the rules AND
- Two (2) years of full-time experience in medical physics in the specialty applied for during the five (5) year period preceding application for an annual license; AND
- An additional six (6) months of work experience during the five (5) year period preceding this application for each additional medical physics specialty requested; AND
- Proof of having passed examination(s) approved by the Board as set out in §601.8 of the rules (copy of certificate); AND
- Three (3) professional references: two (2) medical physicists and one (1) physician practicing in the specialty areas for which application is made.

___ B3. [References: Act, Sec 602.206 and 602.207; Rules, Sec. 601.8(a)(1)(B)]

- Official transcript (including an official school seal) of a master's or doctoral degree which the Board considers and approves as signifying completion of courses in physics, medical physics, biophysics, radiological physics, medical health physics or equivalent courses;
- Two (2) years of full-time experience in the medical physics specialty area applied for during the five (5) year period preceding application for an annual license; AND
- An additional six (6) months of work experience during the five (5) year period preceding this application for each additional medical physics specialty requested; AND
- Proof of having passed examination(s) approved by the Board as set out in §601.8 of the rules (copy of certificate); AND
- Three (3) professional references: two (2) medical physicists and one (1) physician practicing in the specialty areas for which application is made.

___ C. **LICENSURE WITH OUT-OF-STATE LICENSE.** [References: Act, Sec. 602.211; Rules, Sec. 601.7]

- Proof of current licensure to practice medical or radiologic physics issued by a governmental agency in another state, territory, or jurisdiction on Form B (attached) AND
- Evidence that the requirements for licensure in that jurisdiction are substantially equal to the Texas requirements in force at the time of application (provide a copy of the administrative rules and the law from the governmental agency which issued the license).
- Three (3) professional references: two (2) medical physicists and one (1) physician practicing in the specialty areas for which application is made.

___ D. **TEMPORARY LICENSE.** [References: Act, Sec. 602.205; Rules, Sec. 601.8 and Sec. 601.9]

- Meets the requirements set out in methods (Circle One Only) B1, B2, or B3 of this form but has not completed both the experience and examination(s) requirements.
- Three (3) professional references from two (2) medical physicists and one (1) physician practicing in the specialty areas for which application is made.
References from post-secondary school academicians (instructors or faculty members in physics department) may be substituted if the applicant has never practiced medical physics.

APPLICATION FORM

TEXAS BOARD OF LICENSURE FOR
PROFESSIONAL MEDICAL PHYSICISTS
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756-3183
512/834-6655

BUDGET ZZ126
FUND 117

PERSONAL INFORMATION

1. Last Name				
2. First Name		Middle Name		Maiden Name
3. Other Names Formerly Used				
4. Mailing Address _____ City _____ State _____ Zip _____ Telephone Number (Include Area Code): _____				
5. Birthdate:	Month	Day	Year	Birthplace
6. Social Security Number:				
7. Have you ever been convicted of any crime other than a minor traffic violation? Yes _____ No _____ <i>Discovery of criminal conviction information not disclosed may result in denial of your license and disclosure of discovered information to other licensing boards.</i> If your answer is "Yes" to the above question, give a complete explanation on a separate sheet, and send a copy of your disposition papers. NOTE: Driving while intoxicated (DWI) is NOT a minor traffic violation. If you have received deferred adjudication for any crime it does not constitute a conviction.				

PROFESSIONAL PRACTICE INFORMATION

8. Are you <u>currently</u> practicing medical physics? Yes _____ No _____ (Check appropriate box) If "Yes", complete Parts (A) – (F). If "No", complete (G). Active practice in medical physics is not required for a license.	
(A) Primary Professional Work Affiliation:	
(B) Address:	
(C) City:	State: Zip:
(D) Telephone Number (include area code):	
(E) Position/Title:	Normal Working Hours:
(F) Date of Affiliation: (Mo/Yr)	
(G) (Do NOT answer if currently practicing medical physics). Are you currently seeking to practice medical physics? Yes _____ No _____ If "No", what is the purpose of your making application for Texas Licensure? Please explain on separate sheet.	

PROFESSIONAL PRACTICE INFORMATION CONTINUED

9. Circle ONE number below which matches your PRIMARY professional setting (how you spend MOST of your time).

DO NOT CIRCLE MORE THAN ONE (1) CATEGORY.

- | | |
|--|--|
| 1. Not practicing medical physics | 6. Medical School |
| 2. Hospital | 7. Consultant – Self-Employed* |
| 3. Physician's Office or Diagnostic Clinic | 8. Equipment and/or Product Distribution/Development |
| 4. Free-standing Therapy Center | 9. Other (Specify): |
| 5. College/University | |

10. PROFESSIONAL EXPERIENCE: COMPLETE FORM F "Professional Experience" FOR EACH POSITION LISTED
(LIST LAST POSITION FIRST. LIST ADDITIONAL POSITION ON A SEPARATE PAGE)

From mm/yy	To mm/yy	Total yrs/mos	List Position, Most Important Duties and Specialty Areas	Primary Professional Work Affiliation, Name and Address of person to whom inquiry should be directed.

Indicate date Form(s) F were mailed (see instructions on Form F)

*If self-employed complete Form E
"Self-Employment Affidavit"

PROFESSIONAL AFFILIATIONS/CREDENTIALS

11. Are you certified by one of the national boards listed on back page of cover letter?
(Check appropriate box) Yes _____ No _____

If "Yes", list the name(s) of the national board(s) and issue dates, and submit a copy of their certificate with this application form.

National Board Name	Issue Date	Specialty Area

OTHER LICENSES

12. Have you ever held any professional license from the State of Texas or another U.S. state, U.S. territory, District of Columbia, or country outside the U.S.? Yes _____ No _____

If "Yes", complete the following section and follow instructions on the "Verification of Licensure" form included with this application. Please give date form was mailed _____. If "No", go to Question #13.

State/Territory	Title of Certificate or License	Number	Issue Date/Expiration Date

13. Have you ever been denied any license or had any license revoked, cancelled, or suspended? Yes _____ No _____

If your answer is "Yes", give a complete explanation on a separate sheet.

EDUCATIONAL INFORMATION

14. All applicants must enclose an official transcript from an accredited college or university.

Check appropriate box and complete items (A) – (C).

Type of Degree Training
or Certificate: _____ Course _____ Bachelor's _____ Master's _____ Doctoral

(A) Name of College or University:

Location of College or University:

City: _____ State: _____ Zip: _____

Year of Graduation: _____ Degree: _____ Major: _____

Your name at time of graduation:

(B) Name of College or University:

Location of College or University:

City: _____ State: _____ Zip: _____

Year of Graduation: _____ Degree: _____ Major: _____

Your name at time of graduation:

(C) Name of College or University:

Location of College or University:

City: _____ State: _____ Zip: _____

Year of Graduation: _____ Degree: _____ Major: _____

Your name at time of graduation:

PROFESSIONAL REFERENCES

15. All applicants must provide three (3) references. Each reference **MUST** have first-hand knowledge of the applicant's experience in medical physics. In the space below list the names and mailing addresses of at least two (2) medical physicists practicing in a specialty area for which application is made and at least one (1) physician practicing and certified in at least one of the specialties for which application is being made. If application is for a license in the specialty area of medical health physics, the physician may be practicing and certified in diagnostic radiology, radiation oncology, or nuclear medicine. Applicants for a temporary license may substitute post-secondary school academic references. Send Form A to each person listed below and indicate the date the forms were mailed. _____

Type	Name	Current Mailing Address	Specialty
Medical Physicist			
Medical Physicist			
Physician			

AFFIDAVIT

READ CAREFULLY – THIS SECTION MUST BE SIGNED WHILE IN THE PRESENCE OF A NOTARY PUBLIC.

_____, being duly sworn according to law, deposes and says that he/she is the person referred to in this application, that the statements herein contained are true in every respect; that he/she has read and understands this affidavit; that the materials or documents submitted to support this application are authentic and true in every respect; that he/she has read and will abide by the rules and regulations relating to the licensure of Professional Medical Physicists as specified in 22 Texas Administrative Code, Chapter 601, et sequel; that he/she understands that the FEE submitted with application is **NONREFUNDABLE**; and that he/she understands that successful completion of an examination and payment of examination fees are required to upgrade a temporary license to a medical physicist license. The applicant agrees to notify the board office within thirty (30) days of ANY CHANGE of name, mailing address, or place of practice and agrees to return any license certificate and renewal certificate, if applicable, to the board upon the revocation, suspension or cancellation of that license.

Signature of Applicant: _____

Subscribed and sworn to before me this _____ day of _____, 20_____

NOTARIAL SEAL

Notary Public Signature

My commission expires: _____

Typed/Printed Name of Notary

SEND COMPLETED APPLICATION, OFFICIAL TRANSCRIPTS AND CHECK OR MONEY ORDER TO:

Texas Board of Licensure for Professional Medical Physicists
1100 West 49th Street
Austin, Texas 78756-3183

**TEXAS BOARD OF LICENSURE FOR PROFESSIONAL
MEDICAL PHYSICISTS
1100 West 49th Street
Austin, Texas 78756-3183
512/834-6655
Complaints Only 1-800-942-5540**

PROFESSIONAL REFERENCE FORM

Section I (to be completed by applicant)

Applicant Name: _____
(Last) (First) (Middle) (Maiden)

Preferred Mailing Address: _____
(Street or Box Number)

City: _____ State: _____ Zip: _____

Application for: _____ Licensed Medical Physicist _____ Temporary Licensed Medical Physicist

Specialty Area(s): _____ Diagnostic Radiological Physics _____ Medical Nuclear Physics
_____ Therapeutic Radiological Physics _____ Medical Health Physics

Section II (to be completed, signed and dated by a person having first-hand knowledge of the applicant's practice of medical physics and must be mailed directly to the board at the above address):

A medical physicist making a professional reference must be practicing in a specialty area for which the applicant is applying and the physician making a reference must be practicing and certified in at least one of the specialties for which the applicant is applying. If the applicant is applying for a license in the specialty area of medical health physics, the physician may be practicing and certified in radiology, diagnostic radiology, radiation therapy or nuclear medicine. Applicants for a temporary license may substitute post-secondary school academic references.

Name of Person Providing the Reference: _____

Credentials: _____

Board Certification and Specialty Area: _____

Preferred Mailing Address: _____
(Street or Box Number) (City) (State) (Zip)

Telephone (include area code): _____

Are you currently practicing? Yes _____ No _____ Specialty Area: _____

Name of your association with the applicant: (Circle One) Professional Associate Colleague
Supervisor Employer

Length of Relationship: FROM: _____ TO: _____

A. Professional Skills and Professional Standards of Practice (compared to a Medical Physicist of similar experience):

	Poor	Fair	Good	Superior	Don't Know
a. Basic Knowledge	_____	_____	_____	_____	_____
b. Communication Skills	_____	_____	_____	_____	_____
c. Fitness for Independent Clinical Practice	_____	_____	_____	_____	_____

B. Personal Character:

a. Motivation	_____	_____	_____	_____	_____
b. Initiative	_____	_____	_____	_____	_____
c. Assumption or Responsibility	_____	_____	_____	_____	_____
d. Professional Ethics	_____	_____	_____	_____	_____

C. Professional Relationships with the following persons:

a. Clients	_____	_____	_____	_____	_____
b. Colleagues	_____	_____	_____	_____	_____
c. Patients	_____	_____	_____	_____	_____
d. Physicians	_____	_____	_____	_____	_____
e. Others	_____	_____	_____	_____	_____

D. **If applicant is applying for a temporary medical physicist license.**

In your professional judgment is the above named person competent to practice medical physics in the State of Texas as a temporary medical physicist?

YES _____ NO _____ NO OPINION _____

E. **If applicant is applying for a medical physicist license.**

In your professional judgment is the above named person competent to independently practice medical physics in the State of Texas?

YES _____ NO _____ NO OPINION _____

F. **Do you have any reservations about the above applicant?**

YES _____ NO _____ NO OPINION _____

If yes, please explain:

Would you prefer to discuss your reservations confidentially with Board members or staff?

YES _____ NO _____ NO OPINION _____

If yes, indicate daytime phone number (including area code) _____

G. Signature _____ Date _____

- This form must be mailed directly to the Texas Board of Professional Medical Physicists by the person who has signed above.
- DO NOT mail or give this form directly or indirectly to the applicant named on page 1 of this form.
- RETURN THIS FORM DIRECTLY TO:

**TEXAS BOARD OF LICENSURE FOR PROFESSIONAL
MEDICAL PHYSICISTS
1100 West 49th Street
Austin, Texas 78756-3183
Page 2 of 2**

TXMP Form A

**TEXAS BOARD OF LICENSURE FOR PROFESSIONAL
MEDICAL PHYSICIST
1100 West 49th Street
Austin, Texas 78756-3183
512/834-6655
Complaints Only 1-800-942-5540**

VERIFICATION OF LICENSURE

This form must be completed by the state regulatory agency in each state in which you hold or have ever held a license to practice in any profession.

Name of Applicant _____

License Number _____

Profession in which license was issued _____

U.S. State in which license was issued _____

Date License was issued _____

Current _____

Not Current _____

If not current, explain briefly why not _____

Dates of disciplinary action (if applicable) _____

Reason for disciplinary action _____

License issued on the basis of _____

I hereby certify that this information is correct to the best of my knowledge and that based on records available to me the applicant was competent to practice while licensed in this state.

SEAL

Name of Agency

Address

Signature of Official

Title

Date

**TEXAS BOARD OF LICENSURE FOR
PROFESSIONAL MEDICAL PHYSICISTS
1100 West 49th Street
Austin, Texas 78756-3183
512/834-6655
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SPECIALTY AFFIDAVIT

NAME _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

I have applied to become a licensed professional medical physicist with the specialty(ies) in the areas indicated below:

_____ Diagnostic Radiological Physics(DRP)
_____ Medical Nuclear Physics(MNP)

_____ Therapeutic Radiological Physics(TRP)
_____ Medical Health Physics(MHP)

I have at least two years of full-time work experience during the 5 year period preceding the date of application and an additional 6 months of work experience in each of the specialty areas indicated above.

SPECIALTY AREA

DATES OF EXPERIENCE AND PERCENTAGE OF TIME

_____	_____ (2 years)
_____	_____ (6 months)
_____	_____ (6 months)
_____	_____ (6 months)

If above dates overlap, the applicant is requested to clarify, on the back of this form or on an attachment, the number of hours per week which was devoted to each specialty area of medical physics. Where the dates of experience overlap or are concurrent, please be specific. Please type or print legibly.

This information is provided to the Board to supplement my application as a medical physicist.

SIGN THIS AFFIDAVIT WHILE IN THE PRESENCE OF A NOTARY PUBLIC.

To the best of my knowledge this information is true and correct.

I understand that providing false information of any kind may result in the denial of my application, and my failure to be granted a license to practice medical physics in Texas.

_____	_____
Signature of Applicant	Date

Sworn to and subscribed before me this _____ day of _____ 20____
in _____.

Personalized Seal

Signature of Notary Public

My commission expires

Typed/Printed Name of Notary

TXMP

Form

D

**TEXAS BOARD OF LICENSURE FOR PROFESSIONAL
MEDICAL PHYSICISTS
1100 West 49th Street
Austin, Texas 78756-3183
512/834-6655
Complaints Only 1-800-942-5540**

SELF-EMPLOYMENT AFFIDAVIT

This form to be used only to list self-employment experience in medical physics. Other professional experience would be included on page 2 of the application form.

NAME _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

_____ Diagnostic Radiological Physics(DRP)

_____ Therapeutic Radiological Physics(TRP)

_____ Medical Nuclear Physics(MNP)

_____ Medical Health Physics(MHP)

I certify that I have at least two years of full time work experience during the 5 year period preceding the date of application in the medical physics specialty for which I am applying, refer to §601.7(e) of the rules. (Work experience in more than one specialty shall include six additional months for each additional specialty).

Specialty Area	Name of Professional Practice and Address	Beginning Date (mm/eddy)	Ending Date (mm/dd/yy)	% of Time

This information is provided to the Board to supplement my application as a medical physicists.

SIGN THIS AFFIDAVIT WHILE IN THE PRESENCE OF A NOTARY PUBLIC.

To the best of my knowledge this information is true and correct.

I understand that providing false information of any kind may result in the denial of my application, and my failure to be granted a license to practice medical physics in Texas.

Signature of Applicant

Date

Sworn to and subscribed before me this _____ day of _____, 20____

in _____.

Personalized Seal

Signature of Notary Public

My commission expires

Typed/Printed Name of Notary
TXMP Form E

**TEXAS BOARD OF LICENSURE FOR PROFESSIONAL
MEDICAL PHYSICISTS
1100 West 49th Street
Austin, Texas 78756-3183
512/834-6655
Complaints Only 1-800-942-5540**

PROFESSIONAL EXPERIENCE
(duplicate as needed)

Part I to be completed by applicant:

NAME _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

I have applied to become a licensed professional medical physicist with the specialty(ies) in the area(s) indicated below:

_____ Diagnostic Radiological Physics (DRP)

_____ Therapeutic Radiological Physics (TRP)

_____ Medical Nuclear Physics (MNP)

_____ Medical Health Physics (MHP)

1. Professional Work Affiliation:		
2. Address:		
3. City:	State:	Zip:
4. Telephone No. (include area code):	Ext.:	
5. Position/Title:	Normal Working Hours:	
6. Dates of Medical Physic experience (mm/dd/yy):		
7. Brief Job Description/Specialty Area:		

Part II to be completed by agency or individual verifying professional experience:

Please verify the information on the above referenced person. Indicate the medical physics specialty area in which he/she practiced, dates of experience, position/title and provide a brief job description acknowledging that the applicant practiced medical physics during this time period, and return to Jeanette Hilsabeck, Executive Secretary, Texas Board of Licensure for Professional Medical Physicists, 1100 West 49th Street, Austin, Texas 78756-3183.

Date: _____
mm/dd/yy mm/dd/yy

Position/Title: _____

Brief job description/Specialty area: _____

Authorized Signature and Title

Date



TEXAS BOARD OF LICENSURE
FOR PROFESSIONAL MEDICAL PHYSICISTS
1100 West 49th Street
Austin, Texas 78756-3183
(512) 834-6655
Complaints Only 1-800-942-5540

AGREEMENT OF SUPERVISION

Please read §601.9, Temporary License, before completing this agreement.

I. Temporary Licensee/Applicant Information

Name _____

Address (including City, State, Zip) _____

Telephone Number _____ Social Security Number _____

Temporary License # _____ Issue Date _____ Expiration Date _____

Specialty Areas _____ DRP _____ TRP _____ MNP _____ MHP

Employment Setting – Facility Name _____

Address (including City, State, Zip) _____

Telephone # _____

II. Supervisor

Name _____

Address (including City, State, Zip) _____

Telephone Number _____ Social Security Number _____

License # _____ Issue Date _____ Expiration Date _____

Indicate specialty area of supervision for temporary license holder/applicant named above.

_____ DRP _____ TRP _____ MNP _____ MHP Beginning Supervision Date _____ / _____ / _____

Employment Setting – Facility Name _____

Address (including City, State, Zip) _____

Telephone Number _____

III. Affidavit

This section must be signed and dated while in the presence of a notary public.

If the supervisory relationship changes, it is the responsibility of the supervisor to immediately notify the Board office in writing. If for any reason the supervisor does not notify the office, then the temporary licensee must assume this responsibility.

I agree to follow and abide by the Medical Physics Practice Act and Board Rules.

Applicant or Temporary Licensee's Signature

Supervisor's Signature

Date

Date

<p>THE STATE OF _____</p> <p>COUNTY OF _____</p> <p>BEFORE ME, the undersigned authority, on this day personally appeared _____</p> <p>known to me to be the person whose name is subscribed to the section above, and having been by me first duly sworn on oath, acknowledge that he/she had executed the same for the purposes and consideration therein expressed and that the foregoing statements are true and correct.</p> <p>GIVEN under my hand and seal of office, this _____</p> <p>day of _____, 20____.</p> <p>Notary Public in and for _____</p> <p>County, Texas or _____</p> <p>_____ (Signature of Notary)</p> <p>_____ (Printed Name of Notary)</p> <p>My Commission Expires:_____.</p>	<p>THE STATE OF _____</p> <p>COUNTY OF _____</p> <p>BEFORE ME, the undersigned authority, on this day personally appeared _____</p> <p>known to me to be the person whose name is subscribed to the section above , and having been by me first duly sworn on oath, acknowledge that he/she had executed the same for the purposes and consideration therein expressed and that the foregoing statements are true and correct.</p> <p>GIVEN under my hand and seal of office, this _____</p> <p>day of _____, 20____.</p> <p>Notary Public in and for _____</p> <p>County, Texas or _____</p> <p>_____ (Signature of Notary)</p> <p>_____ (Printed Name of Notary)</p> <p>My Commission Expires:_____.</p>
---	--

PLEASE NOTIFY THE BOARD OFFICE OF ANY NAME, ADDRESS, TELEPHONE, OR EMPLOYMENT CHANGES.

RETURN THIS FORM TO:

**TEXAS BOARD OF LICENSURE FOR PROFESSIONAL MEDICAL PHYSICISTS
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756-3183**

MAIL WITH APPLICATION AND FEE

MEDICAL PHYSICISTS APPLICATION COUPON

BUDGET: ZZ126
FUND: 117

NAME_____

SS#_____

**YOU MUST RETURN
THIS COUPON WITH
YOUR PAYMENT.**

PLEASE RETURN TO:
TDH/BOARD OF MEDICAL PHYSICISTS
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756-3183